KENTUCKY BOARD OF SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY

COMMONWEALTH OF KENTUCKY
PO BOX 1360
FRANKFORT, KY 40602
http://slp.ky.gov

APPLICATION FOR INTERIM LICENSURE

(Please check appropriate block)

☐ Speech-Language Pathology
☐ Audiology

1. Name: _____ S. S. No. _____

2. Name as it appears on your transcript: _____

3. Address: _____
Street City State Zip Code
Email address:

4. Phone: Cell: _____ Work: _____ Home: _____

5. U.S. Citizen: ☐ Yes ☐ No. If no, have you declared your intention to become a citizen? ☐ Yes ☐ No.

6. Date of Birth: _____

7. Have you ever applied for licensure as a Speech-Language Pathology Assistant in Kentucky? [ ] Yes [ ] No
If yes, give license number and/or reason for denial: _____

8. Name of other state(s) in which you hold a license.
_____
Please submit a letter of good standing from all states in which you have held a license in Speech-Language Pathology or Audiology

9. Have you ever had a license denied, suspended or revoked in any state or have you ever received a reprimand as a result of unethical, immoral or illegal conduct by any licensure board or agency? [ ] Yes [ ] No If yes, explain: _____
_____
_

10. Have you ever been convicted of a felony? [ ] Yes [ ] No If yes, explain:
_____
_____
_____
_____

11. Education:

School	Names and Locations	Date Attended		Date of Graduation		Number of Hours or Credits	Degrees Obtained
		From	To	Month	Year		
Undergraduate							
Graduate							

AFFIDAVIT

I do hereby swear or affirm that the above statements made by me in this application are true, complete, and correct to the best of my knowledge. I represent that I have read and understand the laws and regulations related to licensure in Speech Language Pathology and Audiology.

Applicant Signature: _____ Date: _____

PLAN OF ACTIVITIES FOR
POSTGRADUATE PROFESSIONAL EXPERIENCE
This portion of the application must be completed by the supervisor

I. **PPE Setting**

A. Facility Name: _____

B. Address: _____
Street City State Zip Code

C. Phone: Work: (____)-_____ _____

D. Beginning Date of PPE: _____ Estimated Ending Date: _____

☐ Full-Time 1260 hours total, 35 hours per week for 36 weeks

☐ Part - Time 1260 hours must be earned within 24 months (96 weeks). Part time work of less than 5 hours of work per week cannot be counted toward PPE. (_____ hrs per week X _____# of weeks=1260 hours)

II. **Supervisor**

A. Name: _____ KY License Number: _____

B. Address: _____

Street City State Zip Code

C. Telephone Number: Cell: ( )- _____ Work: ( )- _____

D. Place / Address of Employment: _____

_____

III. **Plan of Professional Activities**

A. Applicant Activity:

Applicant Activity	Number of Hours Each WEEK to be Spent by Applicant
1. Assessment, diagnosis and / or evaluation	
2. Screening	
3. Habilitation / Rehabilitation	
4. In-service Training	
5. Record Keeping	
6. Other (Specify):	
TOTAL (equal to hours/week)	

B. Supervisory Activity

Supervisory Activity	On-Site Observations (min. of 6 hours per segment)	Other monitoring activities (min. of 6 hours per segment)
Segment One		
Segment Two		
Segment Three		
Total On-Site Occasions*		
Total Other Activities		

***Must be minimum of 18 total in each area**

AFFIDAVIT

I, the named supervisor for the above named applicant for interim licensure, have devised and discussed this plan of activities for post-graduate professional experience with said applicant and accept responsibility for its implementation. Further, I do hereby certify that my Kentucky License is current, and will be maintained throughout this period. I represent that I have read and understand the laws and regulations related to licensure in Speech Language Pathology and Audiology.

SIGNATURE OF SUPERVISOR: _____ DATE: _____